

FLORIDA STATEWIDE HEALTH REFORM DEMONSTRATION FACT SHEET

Name of Section 1115 Demonstration:	Florida Medicaid Reform
Waiver Number:	11-W-00206/4
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SUMMARY

Under the Florida Medicaid Reform Section 1115 demonstration, the State's role changes so that it is largely a purchaser of care, and oversight focuses on improving access and increasing quality of care. The demonstration is an innovative Medicaid reform program that allows beneficiaries to choose managed care plans that best suit their needs. The demonstration allows plans to offer customized benefit packages, although each plan must cover all mandatory services as outlined in Federal law.

In addition to having a choice of Medicaid managed care plans, beneficiaries, can opt-out of Medicaid altogether and use their annual premiums to purchase employer sponsored insurance (ESI). Beneficiaries considering switching to an available employer plan will receive individualized counseling about its potential benefits and risks. Opting-out is voluntary and beneficiaries may choose to rejoin Medicaid within 90 days of opting-out.

Another feature of the Florida demonstration is the establishment of an Enhanced Benefit Account (EBA) program. This program will provide direct incentives to Florida demonstration enrollees who participate in State defined activities that promote healthy behaviors such as weight management, smoking cessation and diabetes management. Beneficiaries will be allowed to accumulate funds in their EBA and use them for approved non-covered health-related needs such as over-the-counter medications. Even individuals who leave the Medicaid program can retain use of any funds remaining in their EBA (for approved health-related uses) for up to three years as long as their incomes remain at or below 200 percent of the federal poverty level.

The State will initially implement Medicaid Reform in two counties: Broward and Duval. It is expected that these two counties will become operational in the first quarter of State Fiscal Year 2007, July – September, 2007. Within a year of implementation in Duval County, Reform will expand to include three contiguous counties to Duval County: Baker, Clay and Nassau Counties. A plan for state-wide implementation will be developed by the end of demonstration year two.

ELIGIBILITY

Eligibility for Medicaid Reform Demonstration. During the initial phase of the demonstration, participation in Medicaid Reform will be mandatory for two eligibility

groups currently covered by Florida Medicaid. The first group is the 1931 eligibles and related group, herein referred to as the TANF and TANF-related eligibility group. The second is the Aged and Disabled group.

TANF and TANF-Related Group - 1931 Eligibles:

- Families whose income is below the TANF limit (23% of the FPL or \$303 per month for a family of 3) with assets less than \$2,000.
- Poverty-related children whose family income exceeds the TANF limit as follows:
 - Up to age one, family income up to 200% FPL.
 - Up to age 6, family income up to 133% of FPL.
 - Up to age 21, family income up to 100% FPL.

Aged and Disabled Group:

- The aged and disabled, comprising persons receiving SSI cash assistance whose eligibility is determined by SSA (income limit approximately 75% of the FPL; asset limit for an individual is \$2,000).
- Children eligible under SSI.

The above groups are mandatory Medicaid eligibles, with the exception of poverty level children up to age one with family income above 185 percent of FPL but below 200 percent of FPL.

Initial Demonstration Voluntary Participation Populations. Florida is using a multi-phased approach to implement the demonstration for beneficiaries not initially identified as mandatory populations. During the initial phase of the demonstration, individuals as listed below may voluntarily participate in the demonstration. The State anticipates that during subsequent phases, individuals identified as voluntary in the groups below, as well as additional eligibility groups not included during the initial phase-in, will be mandated to participate in the demonstration. Specifically, children with chronic conditions participating in the Children's Medical Services Network (providing a coordinated system of health care for children with special needs), foster care children and individuals with developmental disabilities will be required to participate in a reform program upon development and implementation of networks to meet their needs, as specified by the State Legislature.

The following individuals eligible under the TANF and SSI groups listed below will be excluded from mandatory participation during the initial phase:

- Foster care children will be a mandatory population no later than the end of demonstration year three.
- Individuals with developmental disabilities will be a mandatory population no later than the end of demonstration year three.
- Children with special health care needs will be a mandatory population no later than the end of demonstration year three.

- Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD.
- Individuals eligible under a hospice-related eligibility group (by year five).
- Pregnant women with incomes above the 1931 poverty level (by year five).
- Dual eligible individuals.

DELIVERY SYSTEM

The State will contract with multiple managed care plans to provide services. Managed care plans include Health Maintenance Organizations (HMO), Exclusive Provider Organizations (EPO), Provider Service Networks (PSN), and licensed health insurers. The State will reimburse most managed care plans on a capitated basis; however fee-for-service payments may be utilized for PSN providers for up to three years from the date of implementation.

Capitated managed care plans may create customized benefit packages that vary in amount, duration, and scope from Medicaid State plan services. PSNs that continue to be paid on a fee-for-service basis will not be permitted to vary the amount, duration or scope of services from the Medicaid State plan.

BENEFITS

Customized Benefit Packages for Medicaid Reform. Medicaid Reform Plans will have the flexibility to provide customized benefit packages for Medicaid Reform enrollees. The customized benefit packages must cover all mandatory services specified in the State Plan including medically necessary services for pregnant women and EPSDT services for children under age 21. In addition, the plans will cover needed optional services. However, the amount, duration and scope of all covered services, mandatory and optional, may vary to reflect the needs of the population. The plans authorized by the State shall not have service limits more restrictive than authorized in the State Plan for children under the age of 21, pregnant women, and emergency services. The State may also capitate all State Plan services in a demonstration area.

Overall Standards for Customized Benefit Packages. All benefit packages must receive prior-approval by the State and must be at least actuarially equivalent to the services provided to the target population under the current State Plan benefit package. In addition, the plan's customized benefit package must meet a sufficiency test applied by the State to ensure that the benefit package will meet the medical needs of the target population.

Risk Adjusted Premium Development for Customized Benefit Packages. The State will separate the Medicaid premium into two components – comprehensive care and catastrophic care. The distinction between comprehensive and catastrophic coverage is with respect to the development of the premium and related only to the risk level the Medicaid Reform Plan will retain. The aggregate premium will be based on historical

utilization of currently covered mandatory and optional services. Based on this aggregate premium, the State will develop a premium for each component.

Enhanced Benefit Accounts (EBA) Program. This program will provide direct incentives to Florida demonstration enrollees who participate in State defined activities that promote healthy behaviors such as weight management, smoking cessation and diabetes management. Beneficiaries will be allowed to accumulate funds in their EBA and use them for approved non-covered health-related needs such as over-the-counter medications. Individuals who leave the Medicaid program can retain use of any funds remaining in their EBA (for health-related uses) for up to three years as long as their incomes remain at or below 200 percent of the federal poverty level.

Employer Sponsored Insurance (ESI) – In addition to having a choice of Medicaid managed care plans, beneficiaries, can opt-out of Medicaid altogether and use their annual premiums to purchase employer sponsored insurance (ESI). Beneficiaries considering switching to an available employer plan will receive extensive individualized counseling about its potential benefits and risks. Opting-out is voluntary and beneficiaries may choose to rejoin Medicaid within 90 days of opting-out. An enrollee who opts out will be responsible for paying the cost sharing requirements of the ESI plan. Benefits are limited to those provided by the employer through an employer sponsored plan.

Low Income Pool (LIP) – The pool will be established and maintained by the State to provide direct payment and distributions to safety net providers in the State for the purpose of providing coverage to the uninsured.

QUALITY AND EVALUATION PLAN

The State of Florida selected the University of Florida to conduct the independent evaluation of the demonstration. An evaluation design has been developed and includes a discussion of the goals, objectives and specific hypotheses that are being tested through organizational analyses, utilization and payment analyses, and quality of care analyses. The six evaluation objectives identified by the State are to:

- Ensure there is an increase in the number of plans from which an individual may choose;
- Ensure there is access to services not previously covered and improved access to specialists;
- Improve enrollee outcomes as demonstrated by: (a) improvement in the overall health status of enrollees for select health indicators; (b) reduction in ambulatory-sensitive hospitalizations; and (c) decrease utilization of emergency room care.
- Determine the reason for an individual's selection to opt out and whether that selection provides greater value in obtaining coverage;
- Ensure that beneficiary satisfaction improves; and
- Evaluate the impact of the Low Income Pool on access to care for uninsured individuals.

As required under applicable federal laws and regulations, quality of care furnished under Florida Medicaid reform is subject to internal and external review. The State also ensures the effectiveness and quality of care by monitoring access, utilization practices, and beneficiary information, as well as through established service standards in contracts with MCOs.

COST SHARING

Premiums and Co-Payments. The state must pre-approve all cost sharing allowed by plans. In no instance shall cost sharing exceed the nominal levels as specified in the State Plan, as of June 2005 and the following chart. Children and pregnant women are exempt from cost-sharing.

Services	Co-payment / Co-insurance
Chiropractic	\$1 per day per provider
Community Mental Health	\$2 per day per provider
Dental – Adult	5% co-insurance per procedure
FQHC	\$3 per day per provider
Home Health Agency	\$2 per day per provider
Hospital Inpatient	\$3 per admission
Hospital Outpatient	\$3 per visit
Independent Laboratory	\$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first \$300 for each non-emergent visit
Nurse Practitioner	\$2 per day per provider
Optometrist	\$2 per day per provider
Pharmacy	2.5% co-insurance up to the first \$300 for a maximum of \$7.50 a month
Physician and Physician Assistant	\$2 per day per provider
Podiatrist	\$2 per day per provider
Portable X-Ray	\$1 per day per provider
Rural Health Clinic	\$3 per day per provider
Transportation	\$1 per trip

Any changes to cost sharing must be submitted as an amendment to the demonstration or the State Plan for CMS approval.

Employer Sponsored Insurance Cost Sharing. For individuals who voluntarily choose to opt-out into an ESI plan, cost sharing will be consistent with the requirements under the enrollee's specific ESI program. Cost sharing imposed by ESI plans may exceed Medicaid limits.

STATE FUNDING SOURCE

The State of Florida certifies that State/local monies are used as matching funds for the demonstration and that such funds shall not be used as matching funds for any other Federal grant on contract, except as permitted by law.

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